Goals and Some Methods in Psychotherapy: Hypnosis and Isolation

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All psychological treatment procedures appear to involve the manipulation of the patient's behavior. A major target of these manipulations appears to be the patient's values. The process of manipulation may occur covertly or overtly, and may operate outside the awareness of both therapist and patient. Paradoxically positive reinforcement procedures or those that emphasize "love" may pose the greatest threat to the semblance of freedom in the psychotherapeutic situation. Hypnosis and isolation may be effective procedures for manipulating the emotions of "hope" and "anxiety" which are probably the emotions most relevant to the process of changing human behavior.

Recently, there has been a growing recognition that all psychological treatment procedures (psychotherapy, counseling, behavior therapy, psychoanalysis, modern and primitive religious healing [Frank, 1965]), and thought reform or brainwashing (Frank, 1965), which are aimed at either "personality" reconstruction or behavior change, involve the direct or indirect manipulation of values (Rosenthal, 1955; Mowrer, 1964; Patterson, 1958; Dreikurs, 1950; Szasz, 1961; London, 1964; Frank, 1965; Ellis, 1962).

It seems that the label a psychological procedure acquires is largely a function of the cultural value context in which it is practiced, and the degree to which the culturally sanctioned agent of change (psychotherapist, interrogator, witch doctor, or behavior therapist) sincerely believes he is promoting the subject's welfare. A conventional procedure like psychoanalysis would be regarded as "brainwashing" in the Soviet Union, while a procedure like thought reform (Frank, 1965), which the Chinese Communists regard as rehabilitative, is considered "brainwashing" in the United States.

It would seem that one major dimension of similarity in "brainwashing" on one hand and psychotherapy and counseling on the other is the degree to which the agent of change (psychotherapist, counselor, brainwasher, witch doctor) sincerely believes he is promoting the welfare of the subject. The dimension can be operationally defined to some degree in terms of a scale like the Therapist Self Congruence Scale (Truax, 1962; Truax & Carkhuff, 1963). This matter of therapist sincerity or genuineness is the old issue of the Inquisition vs. Protestantism in which the Catholics regarded their procedures as laudable since they were intended to promote the welfare of the subject's soul (we would today probably talk about a self), but the Protestants regarded the procedures as cruel and diabolical.

In general, behavior therapists, witch doctors, and interrogators seem to produce quicker and more dramatic results, probably because they actively manipulate a wider
range of significant environmental contingencies. One important way in which behavior therapists may be distinguished from witch doctors, etc., is the degree to which they employ effective as opposed to "superstitious" (Skinner, 1953) procedures to induce behavior change.

It has been suggested that the voluntary-involuntary dimension (Krasner, 1962) be used to distinguish psychotherapy from brainwashing. Apart from the fact that a great many involuntary patients (institutionalized psychotics, children, and mental defectives) are receiving "psychotherapy," the increasing use of positive reinforcement in behavior modification makes the question of volition academic. As Skinner (1948) has said, "We can achieve a sort of control under which the controlled... nevertheless feel free. ... By careful cultural design, we control not the final behavior but the inclination to behavior—the motives, the desires, the wishes... The curious thing is that in that case the question of freedom never arises [p. 262]." The exclusive contingent use of conditioned generalized positive reinforcers in the form of the "core conditions" (Truax & Carkhuff, 1965) within traditional psychotherapy can render the process of manipulation so covert that "awareness" (Roe, 1959) of being changed will give the subject no protection. The traditional therapist will generally confine himself to relatively un-systematic non-contingent manipulations of social reinforcers inside his office. However, the behavior therapist will, when necessary, invade the patient's natural habitat (Bijou, 1966), his home, office, etc., to ensure the systematic contingent manipulation of environmental factors to induce behavior change. The insight therapies (London, 1964) tend to be overtly manipulative and to induce change at a rate so slow that it is generally imperceptible. The behavior therapies are overtly manipulative and apparently are still reporting dramatic behavior changes. For these reasons, the behavior therapist is more visibly involved in "meddling with values" or even "brainwashing."

If effectiveness of behavior change is the major criterion for evaluating the use of a procedure, then sensory restriction (Gaines & Vetter, 1968; Goldstein, et al., 1966), improved techniques of "punishment" (Azrin & Holz, 1966), etc., may come into wider use. The increasing use of overtly manipulative procedures by psychotherapists brings into the open the conflict between the professed concern of therapists for individual freedom of choice and the control of individual behavior by such procedures, a conflict which has not been clearly recognized and faced by many therapists.

A series of reports (Orne, 1962, 1964; Jackson, 1960; Goldstein, 1962; Frank, 1965; Platonov, 1959) have indicated the power of "demand characteristics" (Orne, 1959a), or expectancies stemming from explicit or implicit suggestions, to affect the results of both psychological experiments and psychotherapy. Imber, et al., (1956) have reported a positive relationship between suggestibility and stay in psychotherapy. Heller (1963) implies that "good" psychotherapy patients and "good" subjects in laboratory social psychological research on persuasion are notably similar. Frank (1965) has reported that psychotherapeutic gains effected by an inert placebo have been maintained up to five years. Frank, Nash, Stone, and Imber (1963) reported a significant overall improvement in 109 psychiatric outpatients receiving a placebo. Paul (1964) reports that a placebo treatment was as powerful a therapeutic tool as experienced psychologists using an "insight" oriented treatment procedure. Rosenthal and Fode (1963) report that expectancies affect even laboratory research with animals.

The placebo effect is a uniquely and
purely psychological effect, and, hence, it makes sense to use it rather than eliminate it in psychological treatment procedures (Patterson, 1966). Krasner and Ullman (1965) note that “It seems reasonable to maximize placebo effects in the treatment situation to increase the likelihood of client change [p. 230].” Freud’s recognition of the importance of what today is called the “placebo effect” is clearly indicated by the following statements. “In order to effect a cure a condition of ‘expectant faith’ was induced in sick persons.... We have learned to use the word ‘suggestion’ for this phenomenon, and Mobius has taught us that the unreliability which we deplore in so many of our therapeutic measures may be traced back actually to the disturbing influence of this very powerful factor...it is disadvantageous, however, to leave entirely in the hands of the patient what the mental factor in your treatment of him shall be. In this way it is uncontrollable; it can neither be measured nor intensified. Is it not then a justifiable endeavor on the part of a physician to seek to control this factor, to use it with a purpose, and to direct and strengthen it? This and nothing else is what scientific psychotherapy proposes [1969, pp. 250-251].” Hypnosis provides a convenient means of manipulating the faith, hope, and trust which are the essence of the placebo effect. Hypnosis is one of the oldest purely psychological techniques for manipulating human expectancies. But the fact that under normal circumstances only a limited number of people are deeply hypnotizable contributed to its neglect. But if routine rapid techniques (sensory restriction) of increasing the proportion of hypnotizable patients can be developed (Wickramasekera, In press) hypnosis may become more widely useable as a pre-treatment procedure.

The present writer has, in two controlled laboratory studies (Wickramasekera, In press), demonstrated with a total population of 61 non-psychiatric subjects that a brief period (one-half to one hour) of sensory restriction will significantly increase hypnotic susceptibility as measured by Forms A and B of the Stanford Hypnotic Susceptibility Scale. Sensory restriction was induced with the use of padded earphones which delivered white noise; the subjects also wore goggles and cotton gloves. The lenses were removed from the goggles and replaced with heavy black cardboard discs to keep out light. The subjects wore loose-fitting heavy cotton gloves which reached to their wrists. They were strictly forbidden to touch or scratch their bodies and were seated on stuffed easy chairs.

A pre-treatment hypnotic induction and demonstration of appropriate but unusual sensory or motor phenomena within hypnosis may be a powerful priming operation prior to actual psychotherapy. In the language of operant conditioning it may be described as increasing the experimentor’s reinforcer value or, in conventional psychiatric terms, may be called increasing the therapist’s interpersonal influence or power in the patient’s eyes.

The patient’s subjective experience of the therapist’s power may be used to shape the patient’s expectation of recovery and hope for the future. Hence, within the context of a trusting relationship with a person who is already recognized as a socially sanctioned healer, hypnosis can become a powerful instrument in the crucial early sessions of treatment, for even temporarily freeing the patient from his burden of past defeats and expectation of future failures. It is important to note that the appearance of the therapist’s omnipotence and patient powerlessness is an illusion, and that the therapist “does not actually acquire the power that the patient ascribes to him [Orne, 1962, p. 81].”

Essentially, we are suggesting that pa-
tient expectancies be appropriately “primed” prior to actual treatment to increase the patient’s readiness for the kinds of learning that await him in psychotherapy, or in other words, that hypnosis be used to increase the therapist’s reinforcer value to the client.

Susceptibility to social influence and to propaganda have been shown to be enhanced by isolation procedures (Gewirtz & Baer, 1958; Stevenson & Odom, 1962; Staples & Walters, 1961; Walters & Karal, 1960; Walters & Ray, 1960; Walters, Marshall, & Shooter, 1960; Pavio, 1963; Suedfeld, 1964; Bexton, Heron, & Scott, 1954; Heron, 1961; Gibby, Adams, & Carrera, 1960; and Cooper, Adams, & Gibby, 1962), and the anxiety arousal interpretation of this effect seems to have the widest support. If prior isolation procedures can also be shown to facilitate the effects of psychotherapy and counseling, then a start would have been made in the direction of demonstrating that such apparently discontinuous procedures as psychotherapy, hypnosis, thought reform (Frank, 1965) or “brainwashing,” counseling, and verbal conditioning share at least one gross motivational parameter. Clinical lore (Wolberg, 1967) and theory (Freud, 1959; Rogers, 1951) already suggest that a minimum level of patient anxiety is necessary for a positive psychotherapeutic outcome. The patient’s susceptibility to influence may be increased by the patient’s involvement in a pre-therapy isolation procedure (Goldstein et al., 1966).

Presently, both jailors and in practice educational behaviorists appear to be using isolation procedures as punishment, in the sense in which the term is defined by Azrin and Holz (1966). Ferster (1958) has shown that the onset of a pre-time-out-or-reinforcement stimulus” operates like punishment (Azrin & Holz, 1966) to inhibit responses associated with the pre-time-out stimulus. When these procedures are used in penal institutions, they are called confinement in the “hole,” and when used in university related laboratory schools they are called placement in the “time-out” room. Isolation, if used differently, may also have some value as a “setting event” (Kantor, 1959) in addition to its function as a punishment procedure.

Mowrer (1960) has previously suggested that all learning is “sign learning” and that effective manipulation of the contingencies of “fear” and “hope” facilitate learning. The use of priming procedures like isolation and hypnosis are aimed at such contingencies, and their use may do something to increase the effectiveness of current psychological treatment procedures. Specifically, hypnosis may be used to heighten the patient’s faith and hope in the therapist, and sensory restriction may be used when necessary to induce the level of anxiety arousal or social deprivation, which will most accelerate the rate of therapeutic learning.

Traditional therapists, probably primarily because of their ineffectiveness and self-delusion, have only slowly recognized the extent to which they shape their successful client’s values and, through their changed values, their specific behavioral goals. It is becoming increasingly clear that every effective therapeutic act shapes the client’s values through what we choose to change and what we do not choose to change in clients, through our rationale (however esoteric and implausible) for the success of our behavioral procedures, and finally through the images of man (Patterson, 1966) and cultural stereotypes unintended but implicit in the tools of our trade (couches, shock generator, hypnosis, tests, M and M’s, conversation, etc.).

It may be that certain therapeutic methods (overtly manipulative and aversive) are incompatible with certain therapeutic goals (the shaping of an independent person), but this is an empirical question
to be resolved by evidence rather than speculation; for example, comparative studies of relevant aspects of the consequences of “successful” treatment in behavior modification and more “insight” oriented therapies.

In a recent conversation (Evans, 1968) Skinner noted that he and Rogers are essentially in agreement on goals, “I’d like people to be approximately as Rogers wants them to be... We agree on our goals; we each want people to be free of the control exercised by others—free of the education they have had, so that they profit by it but are not bound by it [p. 7].” It is the central point of this paper that such a goal may be only relatively attainable, if not impossible to achieve, in any truly meaningful sense because of the inherent nature of the human predicament.

In summary, it is suggested that isolation and hypnosis may take their place among other tools for increasing the client’s readiness for the kinds of value manipulations (Dreikurs, 1950; Mowrer, 1966, 1966; Ellis, 1962; Szasz, 1961; London, 1964) which, when culturally approved, are called psychotherapy, counseling or social rehabilitation, but when culturally disapproved, are described as “brainwashing.”

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